Puget Sound Quarterly

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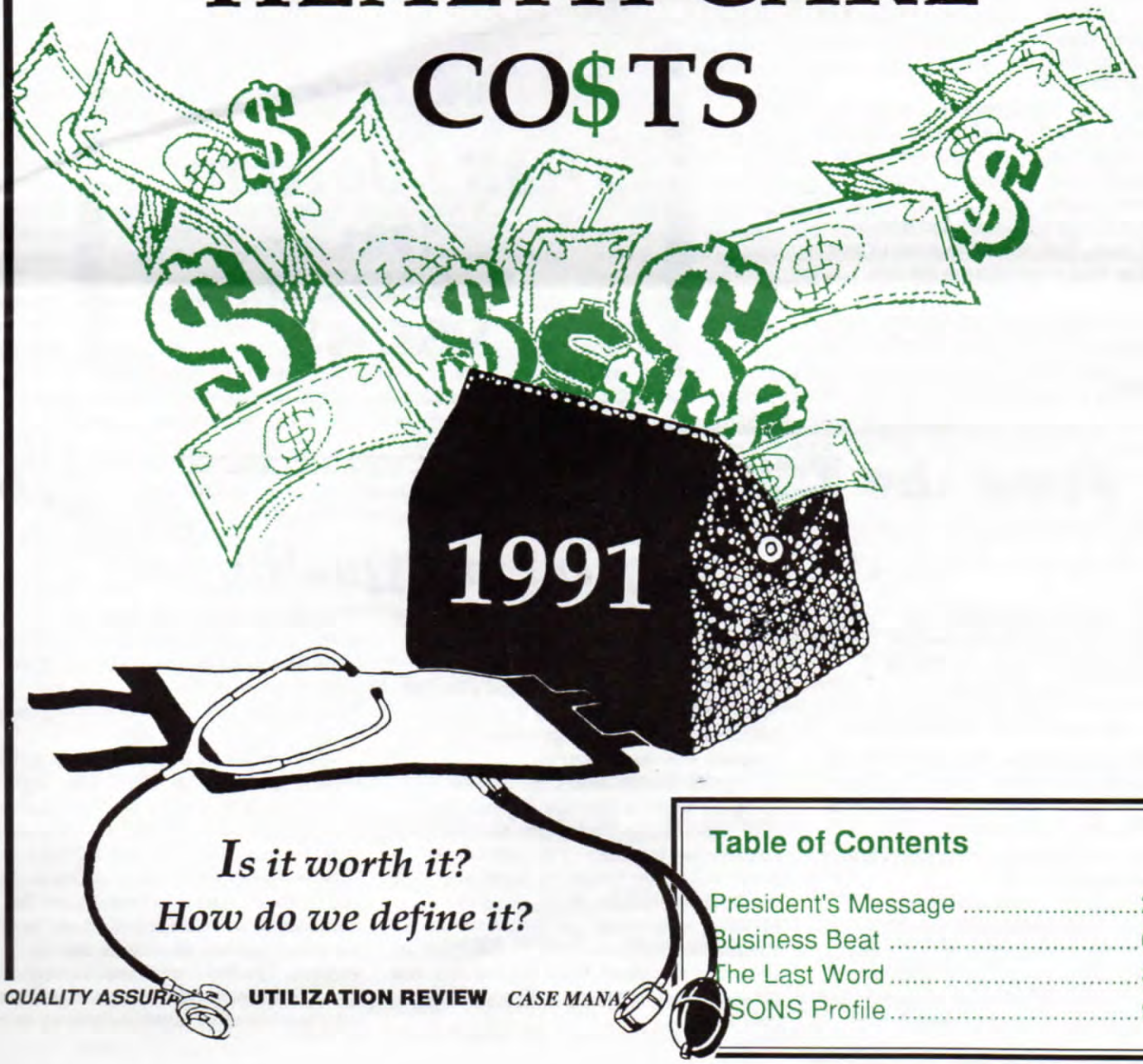
PUGET SOUND ONS

ONCOLOGY NURSING SOCIETY

CASE MANAGEMENT *QUALITY ASSURANCE* **UTILIZATION REVIEW** *CASE MANAGEMENT* *QUALITY ASSURANCE*

HEALTH CARE CO$TS



Is it worth it?
How do we define it?

QUALITY ASSURA **UTILIZATION REVIEW** *CASE MANA*

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President's Message

Joy Miller Knopp, RN, MN, OCN
Oncology Clinical Nurse Specialist
Overlake Hospital Medical Center

1990 was an active and fruitful year for our chapter. As our activities became more diverse, we recognized a need to administer the organization efficiently. A secretarial service was retained which has been extremely helpful in centralizing the chapter's information flow. At present, services which are being engaged include membership data storage, typing and mailings, handling of telephone messages, and the mail box. The first year's review of the charges associated with the secretarial services have shown that it is cost-effective and the board and committee chairs have been relieved of these time-intensive responsibilities.

This year, chapter educationals were held monthly as opposed to quarterly meetings. As well, meetings were held at various hospitals throughout the Northwest Washington region. While meeting attendance was slightly smaller than in recent years, there was an increase in new attendees (nurses working at the host facility) who then became members.

An Ad Hoc Committee was formed to develop a certification review course, a one day workshop held in Seattle prior to our sponsorship of the exam in September. We hope to offer the review course this year and the exam will again be sponsored in September.

Placement of advertising in the newsletter was a priority and a goal that was accomplished on a regular basis this year. This, along with trimming the length of the Quarterly, made the newsletter less of a financial burden for the chapter in 1990.

The Board is continually challenged with the financial management of a large budget, one that supports sophisticated programs and member benefits. To assure the best utilization from our vendor support and financial earnings, a financial Ad Hoc Committee is being recommended for a one year trial. The purpose of this committee would be to provide strategic planning for PSONS regarding financial management. Committee activities that are proposed include: a) coordination/clearing house for vendor/sponsors in response to PSONS requests b) foundation (raising money for membership benefits), c) financial and investment planning ongoing and for the future.

After my one year term as President, I am proud of the many accomplishments of the chapter, made possible only by the member's valuable hours of contribution. I wish Patty Jordan the best in serving as this year's new president.

WELCOME

Patty Jordan

1991
PRESIDENT
PSONS

From the Editor

Cost Containment and Quality

Bonnie Braungart, R.N.
Medical Review Analyst
King County Blue Shield
Seattle, WA
Guest Editor

The Department of Health and Human Services reported $604.1 billion was spent on health care in 1989, 11.1% more than in 1988. This was 11.6% of the gross national product in 1989, the highest proportion for any developed nation.

Various cost containment programs have been instituted to address the increasing costs. Medicare programs like DRG reimbursement have decreased reimbursement amounts. Private insurance and other payors have seen cost increases. Nationwide health care is being proposed to insure universal coverage. There is much controversy over complete government control. Presently alternative combination plans are being discussed. Most likely it will be a coordinated private and government program with costs controls.

Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) and Point of Service insurance plans control costs by directing patients to cost effective/quality providers. Some cost containment features are a prior plan approval requirement, utilization review for medical necessity and benefits management or case management. Per diem, per case and other contracts are made with providers to cut costs.

The bottom line is that providing quality care reduces costs. If a procedure or test is done once that saves money. If the proper treatment is chosen and done correctly, the patient gets healthier sooner saving more expensive care.

To take quality assurance a step further, some health care organizations are beginning to adopt the industrial Total Quality Management Model (TQM) as discussed in the November 24, 1989 issue of JAMA. TQM is a program that sees quality in the eyes of the customer. In health care, the customer is not only the patient and family, but also suppliers, physicians, and co-workers. Quality is evaluated throughout the organization and solutions to problems are coordinated by multidisciplinary teams.

The Measure of Quality Assurance

Kim Bodnar, RN, BSN, CRNI
Account Representative
and
Carol de Groff, RN, BSN, CRNI
Nurse Manager Critical Care
America / New England Critical Care
Seattle, WA

Quality assurance is the process by which an organization assesses the quality of the service or product that it produces. In health care, this refers to the quality of the patient care that is rendered by organizations such as hospitals, clinics, and home health agencies. The intent of quality assurance is to identify areas in which an organization is functioning well, and to identify areas for improvement, by comparing the quality of actual services to a predetermined standard.

Quality assurance assessments generally fall into three broad categories: structure, process, and outcome. Structure refers to "the relatively stable characteristics of the providers of care" including such things as training and licensure of staff, organizational structure, written policies and procedures, and equipment and buildings.

Process refers to "a set of activities that go on ... between practitioners and patients" and includes what types of services are provided to patients with particular diagnoses, and how those services are documented.

Outcome refers to the "change in a patient's current and future health status that can be attributed to antecedent health care." Outcome includes changes in a patient's physical, mental, or social health that relate to the care that the patient received. All three aspects are important in assessing quality, however, recently more emphasis has been placed on assessing patient outcomes.

Outcome monitors have become the focus of Critical Care America's Quality Assurance program. Presented here are our goals for the cancer patient receiving home pain management. The critical indicator is that the patient maintain pain control without complications or side effects. Outcome indicators include:

Patient will experience no pump problems resulting in an interruption of pain control of > 4 hours;

Patient will experience no access related problems resulting in an interruption of pain control of > 4 hours;

All documented readmissions are related to disease process not home IV therapy;

Patients pain is controlled (<2 on pain scale of 1-10 or as otherwise objectively noted in nurses notes) or physician is contacted for evaluation of medication regime.

A brief case report may best describe our program. JK was diagnosed with adenocarcinoma of the right breast with metastasis to the bone. Aggressive chemotherapy was initiated after a simple mastectomy and JK would require home pain management upon discharge from the hospital. Our nurse met with JK prior to discharge to complete a baseline level of pain (intensity, duration, location). JK's pain would be controlled with a low dose continuous infusion of intravenous morphine sulfate via the Hickman catheter and the PCA feature on the pump. Orders were obtained for sublingual morphine should there be any interruption in intravenous pain management due to a catheter or pump problem. JK expressed a desire to maintain a pain level of "2" or less while on home pain management.

JK and her husband were instructed in the use of the small ambulatory PCA pump and the care of her Hickman catheter prior to discharge. Instruction continued once she was home and included troubleshooting the pump and the catheter. Six days after discharge, JK was administering PCA doses every 4-6 hours to maintain pain control at a "2" or less. The physician was contacted to request an upward adjustment of the continuous infusion of the morphine after an assessment was completed. Four weeks after being home on IV morphine, JK's husband called in the evening to report the catheter was leaking due to a small rupture. They were instructed by the nurse to stop the infusion, clamp the catheter, wrap a sterile 2 X 2 around the rupture, and administer sublingual morphine for pain control until a nurse arrived. Orders for line repair had been obtained prior to discharge. The nurse was able to repair the catheter with a Hemed glueless repair kit which allowed JK to resume IV morphine only 2 1/2 hours after the rupture. The nurse stayed with JK for an hour after the repair to assure that her pain would remain at a "2" or less. The physician was notified of the repair and that JK had maintained adequate pain control. After 6 months of home therapy, IV morphine doses were reduced and JK was converted to oral Dilaudid.

Outcome: JK was managed on home pain management while maintaining her goals for pain control. The Hickman catheter had remained free of infection, no pump problems occurred resulting in the cessation of IV morphine, the catheter was repaired without incident or interruption of pain control, and the physician was contacted regularly for an evaluation of JK's medication regime.

CONGRATULATIONS !

SUSAN DYER

Group Health Cooperative

Winner of the Lane Adams Award for Nursing Excellence!
Awarded nationally by the American Cancer Society

Medical Case Management

Bonnie Robb, RN, BSN
Case Management Program
Health Incentives
Lynnwood, WA

The role of the Medical Case Manager has yet to be clearly defined. It is my hope that this article will give the reader at least an overview of Case Management and how it may affect your practice.

Medical Case Management (MCM) dates back to the 1940's when rehabilitation based case management programs were started in response to worker's compensation cases. During the past decade there has been a significant increase in the number of MCM programs. Now nearly every major private insurer in the United States has MCM. These programs may also be found through employers, HMO's, PPO's, and through private case management firms.

MCM is designed to contain costs and provide high quality care for people who have suffered a catastrophic illness or injury by targeting appropriate resources to meet the individual needs of the patient and family. Those who may benefit from MCM include patients with high risk pregnancy, neonates, CVA's, multiple sclerosis, AIDS, end-stage cancer, and psychiatric disorders. Case managers may be found in the provider sector, rehabilitation facilities, hospitals, home care agencies, or infusion therapy companies. They may include nurses and social workers. Generally their focus is to provide management of the cases associated with their services.

Case managers may also be found within the payor sector, i.e. employer groups, third party administrators and major insurance companies. Often these case managers are an extension of the insurance pre-certification / UR programs. Their programs are designed to reduce costs as well as guide employees and dependents toward appropriate utilization of services.

As an independent case manager, I see my role as patient advocate. I may arrange for funding for respite care, outpatient day treatment, home modifications or transportation. I assist by working with patients at the acute care hospital, arranging for discharge perhaps to a hospice center, or monitoring the progress at home. I may ascertain what is covered by the benefit plan and arrange for payment for uncovered expenses. My goal is to determine the needs of the patient, determine the obstacles to getting those needs met, and arrange for ways to remove those obstacles. I work with the patient, the family, the physician, as well as vendors and facilities. I continue to follow the patients long after their discharge home and continually work to effect quality as well as cost of care received.

The patient's family as well as the physician are essential to the success of the MCM plan. The physician often lack the resources and knowledge to develop a comprehensive plan of care for the patients. The family is often relieved to know the MCM is available and frequently I am the one person who is involved with the patient and the family over the full course of a health problem.

The following case example illustrates how MCM interfaces with physicians, nurses, discharge planners, patients, and families as well as resources in the community. John, 41, was admitted to the hospital with mental confusion. He had recently been diagnosed with AIDS. I began my assessment by discussing John's case with his physicians, his ex-wife Nan, and the discharge planners in the hospital. John was diagnosed with encephalitis with subsequent dementia. A ventriculoperitoneal shunt was placed and discharge was anticipated within ten days. John would need 24 hour care as he was unsafe to be home alone unattended and was not able to remember to take his medications.

Nan agreed to take John to her home. Due to her work schedule she would not be available during the day to care for John. An exception to benefits was arranged to cover the 9 hours per day of custodial care needed for John to stay at home. The hospice benefit was opened and the hospice nurses were to provide the skilled nursing visits.

During the next 2 months John was able to stay at home with attendant care in place. His condition improved dramatically, his mentation cleared and he was no longer in need of supervision. He was readmitted briefly when his shunt occluded and Nan was taught to assess early changes in his mentation and alert his treating physician. Eight months later, John was readmitted with a dramatic decline in mentation. It was thought again that the VP shunt had occluded. However, he was found to have contracted CMV retinitis. A Hickman catheter was placed and twice daily infusions of DHPG were started. Discharge was planned for 8 to 10 days.

Having worked with Nan for the past 10 months, it was apparent that she would not be able to manage the infusions at home. We explored options for hospice placement at a local AIDS facility and John was placed on a long waiting list. In my discussion with the discharge planner, several other facilities were suggested and John was accepted into a local rehabilitation facility with a skilled nursing unit. John's health plan administrator agreed to let us utilize his skilled nursing benefit. I negotiated the cost for his care, arranged for the IV DHPG therapy, and he was transferred after a 15 day inpatient hospital stay.

During his stay at the rehab facility, John received not only skilled nursing care, but physical and occupational therapy, nutritional and recreational therapies. The goal was to provide continual support in a safe environment that would enhance the quality of John's life. His mentation improved and he was able to accomplish more and more of his own ADL's. John was able to go home for several weekend passes. It was hoped that he could have been discharged home. However, within several weeks John's condition deteriorated and he died after six weeks at the facility. He had received high quality cost- effective care as an alternative to hospitalization.

The medical case manager may be the one person, having in some cases been involved with the patient over a long period of time, who is best suited to evaluate current needs. It is my hope that we will be able to continue to work closely with other nurses, physicians, and discharge planners. Case Management serves as the bridge between the health care professionals and the vendors and payors who together have the goal of administering the best possible health care services to the patient. I encourage you to ask your patients if a case manager has been working with them and for you to discuss the needs of your patients with the case manager. We are a part of the team and we want to assist in whatever way we can.

Utilization Review

Wendy Reiner, RN, BSN
and
Janet Schjoneman, RN
Health Care Review Coordinators
Valley Medical Center
Renton, WA

Early in my nursing career I was very cognizant that there were job alternative to floor nursing to be found in the local hospital where I was employed. I specifically had my eye on the nurse who wandered the wards with a white starched lab coat carrying a large brown clipboard.

Many jobs and many full moons later I found myself wearing that wrinkled white coat and this is my story . . .

Utilization Review - what a funny name. Utilization of what? The Joint Commission on Accreditation of Hospitals defines Utilization Review (UR) as appropriate allocation of hospital resources striving for quality patient care in the most cost effective manner. Most commonly the term UR applies to a review process done concurrently during hospitalization to determine the individual patient's need for admittance to the hospital and to determine that they need continued inpatient hospitalization to meet their medical needs.

UR was officially mandated in 1965 by a Social Security Amendment for Medicare to provide cost effective care. At that time, the hospital either did their own reviews under strict Medicare guidelines or had their care monitored by the Professional Review Organizations formerly knows as PRO's.

As the years passed, new programs were instituted, with the most recent being the DRG system (Diagnosis Related Groupings), DRG's were supposed to be a way for the federal government to cut costs by paying hospitals a redesignated amount for each hospitalization based on the diagnosis instead of the billed charges. For example, if a patient was admitted with a heart attack, the hospital would get a predetermined fee, unrelated to the actual length of stay or the actual charges. What an innovative idea. This would put cost containment responsibilities on the hospital and physicians to give the most cost effective care without compromising quality.

Just as the government got interested in cutting the rapidly growing high cost of medical bills, the insurance industry followed suit. The large insurance companies had worked as fiscal intermediaries for Medicare and had become adept at managing statistics on normal length of stays for specific diagnoses. They also had gotten quite sophisticated in creating fancy computer systems to track UR information. It is estimated that over 60% of all insurance companies and health care payors are not utilizing some type of managed care for their enrollees. These programs may include pre-certification for hospital admissions, continued concurrent monitoring, case management, and discharge planning.

As all of this was happening, the hospitals realized they needed to get a handle on this activity and hired nurses in the role of utilization review coordinators to help be the liaison between the hospital, the patient, the physician, and the payor source.

A DAY IN THE LIFE OF A UR NURSE . . .

My day starts early as I collect a listing of patients and their demographic information from our computerized system. We have several UR nurses and divide our hospital by units to save time and to allow physicians and other staff to develop a good working relationship with the nurse assigned to their unit. A good UR nurse can review approximately 50 patients per day. I also collect a list of requests for concurrent reviews from insurance companies and third party payors. Last of all I grab the infamous white lab coat and brown clipboard and off I go to the nursing units.

As I enter the unit, I do a quick check to see if any physicians are on the unit. I will review their charts first in case I have any questions or concerns so I can address them in person. As I turn my attention to the first chart, many things go through my mind. Is the diagnosis clearly documented in the chart? Was the patient sick enough to be admitted? Does the patient continue to exhibit symptoms that require inpatient hospitalization? In order to meet medical necessity criteria, the patient not only has be to sick enough to be in the hospital but also has to be receiving services to require hospitalization. Next I look to see is the patient being treated in the most cost effective settings. For example, CCU versus telemetry, medical floor versus Medicare exempt rehabilitation unit, etc. Finally I look to see if there is a discharge plan documented in the chart or are there any road blocks that could potentially delay discharge?

If I find any concerns I discuss them with the charge nurse or nurse manager and then frequently contact the physician and make recommendations. I also attend weekly discharge planning rounds with a multi-disciplinary group that includes physical and occupational therapy, social work, home care coordinator, dietary, and the charge nurse. My role these is to educate on insurance coverage, provide concurrent patient information and to assist with discharge planning.

Continued on Page 7

SAMPLE DISCHARGE SCREENS

- Care and services could be rendered safely and effectively in an alternative setting
- Temperature below 100 degrees Fahrenheit for at least 24 hours
- Prescribed diet tolerated for 24 hours without nausea or vomiting
- Passing flatus / fecal material
- Voiding or draining urine (at least 800 cc) for last 24 hours
- Type / dosage of major drug unchanged for last 2 days
- No parenteral analgesics / narcotics for last 24 hours
- Wound healing
- Able to clean and care for drainage tubes
- Refuses therapy
- Refuses available Skilled Nursing Facility bed

Puget Sound Chapter of the
Oncology Nursing Society

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Editor: Anna Williams

Submit materials for publication to Anna Williams, PSONS Editor, Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, Washington, 98125-4357. (206) 386-2013

PUGET SOUND CHAPTER HOTLINE!
PSONS has a telephone answering machine. For questions, concerns and comments regarding Chapter activities, please call:
(206) 361-4736
24 Hours
Leave your message, name, telephone number and best times to reach you, on the tape recording.

Business Beat

Judy Kornell, RN, MN
Pain and Toxicity Research
Fred Hutchinson Cancer Research Center

Symposium

Patricia Buchsel and Joan Bjeletich did a wonderful job as co-chairs of the 1991 Symposium and reported that 156 nurses attended each day. Many thanks to their committee: Pat Jordan, Mary Seybold, Margie Anderson, Ann Winkes-Breen, Joy Knopp, Debbie Noble-Irons, Karen Purcella, Mona Epp-Stage, Andra Davis, & Mary Ann Rupe.

Nominating

We are making progress! Seventy-five ballots were returned with only 1 invalid. President-Elect is Bev Vincent Davis and Treasurer will be Judy Petersen. Congratulations and best of luck as our new officers.

Education

Betty Gallucci was saluted for her efforts as dual education chairperson and secretary. Welcome to new education committee volunteers Andra Davis, Carla Jolley, and Deborah Hummell. . With help from task force and standing committees six educational programs were offered during the past year at an average cost per offering of $375. Scholarship awards to the annual PSONS Symposium were received by Susan Ford and Patricia Owsley. Travel awards to the annual ONS Congress in San Antonio were received by Veneta Christensen of Highline Hospital and Mary Patterson of Internal Medicine Associates of Yakima. ***Future meetings*** : A panel discussion on the role of nurses in research coming up April 24th at Fred Hutch sponsored by the Research Committee & the annual post-Congress wrap up will be held June 21st at the University Faculty Club.

Membership and Public Relations

PSONS had a total of 312 members in 1990 and 256 have already renewed for 1991! Susan Ford and Irene Karlsen maintained the membership roster and renewals until PSONS hired a secretarial service in December of 1990. Members have been profiled in the *Quarterly* who represent the diversity within the organization. As Sue and Irene are retiring we need new volunteers to fill their shoes. If you are interested in becoming involved please call Patty Jordan.

Government Relations

The Government Affairs Committee has submitted a resolution to ONS! The resolution calls for support of the oncology nurse in dealing with ethical decision making relative to client- centered care and ethical-legal issues. The resolution which will be discussed on the floor of the National ONS Business Meeting in San Antonio is endorsed by Gloria Felde, Margot Hill, Patty Jordan, Stephanie Sarantos, Joy Knopp, Renee Yanke, Ingrid Nielsen, Mary Seybold, Ann Reiner, and Barbara Fristoe.

On the local congressional scene, PSONS member Mona Epp Stage testified before the House Health Care Committee as a member of a panel facilitated by TACC (Tobacco Addiction Coordinating Council). TACC is a coalition of about 50 participating professional and public organizations including PSONS, WSNA, WSMA, American Heart Association, American Cancer Society, and many others. Mona testified in support of House Bill 1753 calling for heavier restriction on vending machine and single cigarette sales, as well as calling for a new tax on cigarettes sales to support educational programs directed at prevention. The Health Care Committee is chaired by Representative Dennis Braddock of Bellingham. Mona was assisted in her lobbying efforts by Patty Joynes, Executive Director of WSNA, Marianne Lile, WSNA lobbyist, and Maribeth O'Connor, Government Affairs for Group Health Cooperative. Thank you Mona for your efforts in this important legislative arena.

Research

The Research Committee is establishing a journal club and planning the April 24th educational program featuring nurses who work on pharmaceutical research protocols, a nurse clinician who generated a collaborative research project, and a doctorally prepared nurse who develops research protocols. Welcome to new members Kathleen Block and Diana Wilkie.

Special Announcement

Fran Lewis, R.N., Ph.D., ACS Professor of Oncology Nursing and Professor of Nursing at the University of Washington announces the ACS Summer Colloqium. Eight staff nurses from around the state will be chosen to attend a 2 week no fee training experience in cancer nursing. Nurses will be provided with relevant clinical experiences and attend workshops given by leading oncology nurse specialists in the Seattle area. A $300 stipend is also included. For information please call Robert Dingman at the Washington Division American Cancer Society at 283-1152 or Dr. Fran Lewis at 525-4479.

Utilization Review

Continued from Page 5

Many times during my busy day physicians come to me with their concerns and questions about documentation and ask questions about insurance coverage. It's interesting because when I started as a UR nurse, many physician felt we were policing their care. In the last few years by utilizing nursing professionals to do UR, we have developed a trusting educational role with our medical staff. We all work together as a team.

WHAT HAPPENS WHEN A PATIENT DOESN'T WANT TO LEAVE THE HOSPITAL?

There is specific criteria that UR professionals utilize nationwide. Most commonly used is the Interqual ISD-A Criteria for Hospitalization." This criteria includes a screen for discharge. (See Table on Page 5.) Sometimes a patient isn't ready for discharge for a number of reasons, but no longer meet inpatient criteria. It is the UR nurse's job to talk with the patient and family to explain that since the patient doesn't meet accepted criteria for continued hospitalization he/she may be responsible for any future hospital costs. This process is called decertification. Decertification involves identification by the UR nurse of the lack of need for continued hospitalization, discussion with the attending physician, a consensus between the attending physician and another physician that has reviewed the case and agrees that the patient no longer requires inpatient care. The final part of the process is explaining carefully to the family that we are not asking the patient to leave but informing them that due to lack of intensity of service, if they continue to utilize the hospital they may be responsible for all further costs incurred.

OTHER JOBS THE UR NURSE IS RESPONSIBLE FOR

The UR nurse in our hospital helps chair the combined UR / Quality Assurance meetings for the specific physician departments. We are responsible for identifying and organizing cases for physician review and writing agendas and minutes in the JCAHO format to help document we are meeting accreditation requirements.

So the next time you see that white jacket and clipboard in the hospital you can be assured there's more than meets the eye.

Clinical Practice Review

"Unproven Methods of Cancer Management: Fresh Cell Therapy"
CA - A Cancer Journal for Clinicians 41 (2): 126-128

Article Review by
Anna Williams, RN, MN

The American Cancer Society (ACS), in a recent series of articles, attempts to scientifically examine the issues surrounding unproven cancer therapies. In the most recent issue of CA - A Cancer Journal for Clinicians, the editors discuss one such therapy known as "fresh cell therapy". The article begins with an officially worded statement from the ACS that individuals are "strongly urged" not to seek this treatment. The article goes on to review the literature and other information supplied by the proponents of the therapy.

Fresh cell therapy, first developed in the 1930s, is attributed to the work of Dr. Paul Niehans, a Swiss surgeon and endocrinologist. Dr. Niehans believed that the development of cancer could be attributed to aging epithelial cells. He surmised that a regenerative process was necessary to reverse this process. In 1931 he injected parathyroid cells from a calf into a patient who had a damaged parathyroid gland. The patient recovered and Dr. Niehans came to the conclusion that the injection of embryonic animal cells could regenerate or repair human cells and organ structures. Fresh cell therapy is the injection (intramuscular or subdermal) of fresh embryonic animal cells taken from the specific organ or tissue that corresponds with the unhealthy organ or tissue of the patient. The injected cells are thought to travel to the affected organ and begin repairing or "revitalizing" the damaged area as well as augmenting the immune system in general. Although stating that no scientific literature from peer-reviewed journals could be found examining fresh cell therapy, information provided by La Prairie Clinic in Montreux, Switzerland estimated that 65,000 patients have been successfully treated with this therapy. Dr. Niehan's work included the statistics that patients treated with cellular therapy had a cancer incidence of 1.2%, while the general Swiss population had a 20% cancer incidence. Several clinics in Mexico offer fresh cell therapy, including the American-Biologics Research Facility in Tijuana and the Hospital Santa Monica. The treatment course ranges from 7 days to 21 days, and costs from $2,300 to $6000.

The article goes on to discuss the potential side effects of fresh cell therapy from FDA findings and other European health monitoring bodies. Chief amongst the concerns is that without regulatory standards the products can and have been found to contain viral and microbial contaminants and in addition have significant risk for autoimmune or anaphylactic consequences. One graphic example described was that of a 60 year old woman who died of leukoencephalitis two weeks after treatment. Investigators felt that the fatal outcome was the result of the injection of animal brain tissues containing myelin on which viruses were growing.

In clinical practice oncology nurses are confronted with discussions about unproven therapies. The dilemma we face is the balance between facilitating realistic hope for patients and supplying information about the risks of unproven therapies. At the very least we need to educate ourselves about the choices that our patients are making and support each other in this controversial area of clinical practice.

Congratulations 1990 Newsletter Award Winners

Excellence In Writing

Best of 1990
"Nurse Retention"
Ann Reiner, RN, MN, OCN
Virginia Mason
Medical Center
Summer 1990

Honorable Mention
"AIDS and Suicide"
Margo Bykonen, RN, BSN
Janet Welle, RN, MN
Swedish Hospital
Medical Center
Spring 1990

Honorable Mention
"Chemotherapy Update"
Alice Albright, RN, BSN, OCN
Swedish Hospital
Tumor Institute
Winter 1990

PSONS Profile

ANN McELROY

I sit here, at my kitchen table, sipping coffee and wondering when will this rain stop coming down. Earlier this year, half way around the world, another PSONS member also wondered if it would stop raining. She is Ann McElroy, and her rain was SCUD missiles.

Ann, a longstanding PSONS member and former Vice President, lives in Riyadh, Saudi Arabia, and works at the King Faisal Hospital (a civilian royal family facility). Living in Saudi Arabia for almost two years, Ann was actually out of the country on vacation when war broke out in January. Ann was allowed to return to Riyadh in mid February because she is a nurse. Deemed an essential employee, they welcomed her return. Particularly regarding the fact that about half the beds were closed because 50% of the hospital staff had left the country (Note: King Faisal is staffed primarily with foreign health care providers).

So. . . being out of the country when war broke, what drew Ann back? A combined duty to serve — not only her sense of commitment to the hospital but her sense of duty to country and comrade. The

hospital had begun to "gear up" for war casualties. Ann's skills would turn to MASH-like nursing as opposed to her oncology expertise. She felt this was one way she could personally thank the military folks for their service in the Gulf War. Additionally, the friendships Ann has made in Riyadh drew her back despite the war.

Ann says despite the success of the Patriot missiles, she and others still get that "Adrenalin Rush" when the air-raid sirens sound. People became so weary due to lack of sleep during the earlier raids, that many would turn off TVs and radios in order to get some rest. They would even spend evenings on roof tops watching the Patriots intercept SCUD missiles. The tragedy in Dhahran, when a U.S. barracks was hit, made people a little more cautious again. Ann says she knows of no fatalities due to missile attacks in Riyadh.

She wears a constant reminder of the war, a gas mask in a plastic grocery bag. It has been tried on in practice, but she hasn't had to use it for the "real thing," luckily. Ann and her co-workers have not had restrictions placed upon them due to the war. The only requirement is not to look "American." According to Ann, it is pretty easy not to *look* "American," but once you open your mouth it gives you away.

When we think about the Gulf War, pictures of service men and women quickly pop into our minds. We need to also think about the civilian men and women whom have chosen to remain in various parts of the Middle East. Ann, we want you to know we think of you often and pray for your continued safety.

PSONS Profile was contiributed by Susan Ford, RN, MN, CS, OCN.

Welcome to New PSONS Members

Colleen Jurkovich	Providence - Everett
Wendy Brown	UW Medical Center - Seattle
Don Miller	Providence - Everett
Charles Moody	UW Medical Center - Seattle
Lynda Musgrove	Tacoma General
Shyla Rees	UW Medical Center - Seattle
Clifford Ells	St. Joseph's - Tacoma
Connie Thompson	Tacoma General
Denise Estabrook	New England Critical Care - Seattle
Connie Carlsen	NW Cancer Center - Seattle
Holly Glass	NW Cancer Center - Seattle
Marcy Headley	Sacred Heart - Spokane
Marcella Shoemaker	Home Health Care of WA - Redmond
Cathy Thomas	NW Cancer Center - Seattle
Karen Treat	Visiting Nurse Service - Bellingham
Laurine Morgan	Eastside Hospice - Bellevue
Carol Kalina	VA Medical Center - Seattle
Judy Pendergrass	St. Joseph's - Bellingham
Linda Sirman	UW Medical Center - Seattle
Debra Morris	St. Joseph's - Tacoma
Marily Ahrens	Swedish Tumor Institute - Seattle
Jean Borth	St. Joseph's - Tacoma
Karen Iverson	St. Joseph's - Lewiston, ID
Claire Keller	Fred Hutchinson - Seattle
Sherry Kuzan	Valley Medical Center - Renton
Angela Rowbotham	Spokane Hematology-Oncology
Diane Cockburn	Walla Walla Clinic
Setsuko Hayes	Fred Hutchinson - Seattle
Melody Kue	Skagit Valley Hospital - Mt. Vernon
Wendy Lagozzino	Swedish Tumor Institute - Seattle
Patricia Line	Good Samaritan - Puyallup
Sandra Stephen	St. Elizabeth - Yakima
Wilma Wayson	Sustaining Care - Seattle
Jeanne Brown	U of WA School of Nursing - Seattle

PSONS gratefully accepts a donation from JoAnn Kowalski. Thanks, JoAnn!

The Last Word

Renee Yanke, RN, MN, OCN
Oncology Clinical Nurse Specialist
Whidbey General Hospital
Coupeville, WA

The annual symposium was held in February and it was a big success. A Friday night reception was very enjoyable. The sunset was beautiful to take in while talking with people you hadn't seen in awhile and catching the view from the top of the Security Pacific Building. A BIG Thank you to all those that made the Symposium such a treat.

Congratulations go out to Patricia Buchsel (Seattle U.) who received the Outstanding Alumni of Seattle University Award. Ten alumni will be presented this award on April 24th, 1991 in honor of the University's centennial. Way to go Patricia!

Kathy Itoh-Millson (Whatcom VNS) had a baby boy on December 11th 1990 weighing in at 8 lbs. 14 oz. and named Matthew David Millson. Kathy is "playing" on her baby leave until April 1st when she will return to work. (By the time you read this, Kathy, you may be already back to work, so . . .Congratulations and Welcome Back to Work).

Remember Janet Nelson went to Texas? Laurie Hess took her place at Providence Hospital in Everett as the Medical Oncology and Surgical Units Manager. Vicky Whipple will continue as the Oncology CNS and add to her duties the role of the Cancer Program Coordinator. Good luck to both!

Carla Jolley (HHC of Whidbey General Hospital) joined the staff this fall as the Oncology CNS for HHC, and finished her thesis in December. Way to go Carla and welcome to WGH!

Word was received that the PSONS symposium was the "take off point" for Lori Rivers- Ashmore's (St. Mary's, Walla Walla) honeymoon. Lori was married in December of 1990, she and her husband came to PSONS before leaving for Puerto Vallarta. Best Wishes to you both - we're impressed with such dedication!

From Wenatchee Betsy Tontini (Wenatchee Valley Clinic) reports that Mickie Romero is the new Oncology Clinic Coordinator. She is new to Washington, coming from Arizona, and is learning her way around. Welcome! Betsy continues as the Cancer Resource Nurse and keeps very busy. She reports that she is doing great personally, especially since her son is in remission. She has appreciated everyone's support. Betsy - it's great hearing this news!!

NOTES FROM THE EAST SIDE OF THE MOUNTAINS

Debbie Coombs, RN, MN
Group Health Cooperative
Spokane, WA

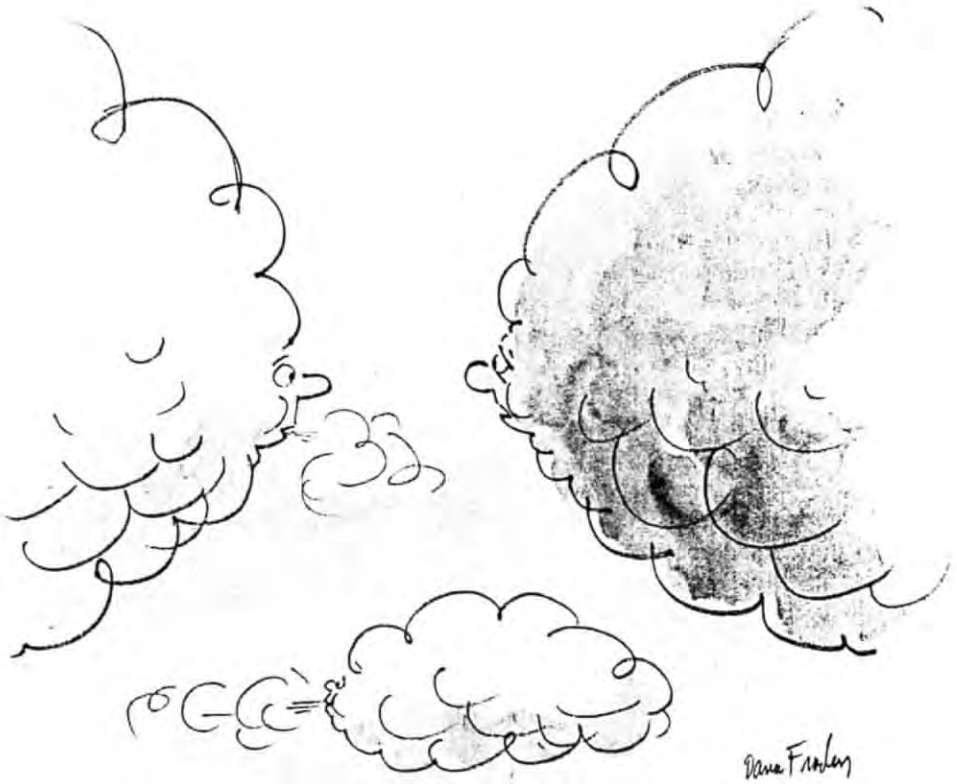
Group Health Northwest is just booming in the Oncology Department, with hospital discharge planning, chemo, home care coordination, and phone triage ... I manage to keep busy.

The Inland Northwest ONS Chapter Interest Group continues to move toward application for charter. We have monthly meetings, with an average of 25 participants from Spokane and Northern Idaho.

Our Symposium is coming up March 27th and April 3rd and is called Early Detection and Prevention targeted for office staff in general practitioners practices. Susan Herbst at Kootenei Medical Center is working with the critical care nurses to develop a symposium about Oncologic Emergencies. This is a very exciting collaboration for all of us, and you are all welcome to join us.

Anna Quincy (Sacred Heart - Spokane) is chair of the ACS Division Services and Rehab Committee, teaches the traveling chemotherapy workshop, and leads the "Up with Living" Cancer Support Group.

Eastern Washington and Northern Idaho are having a great time and growing in the ONS spirit. Come on over!



"Do you have some Tums? I'm filled with acid rain."

PSONS MEMBERSHIP

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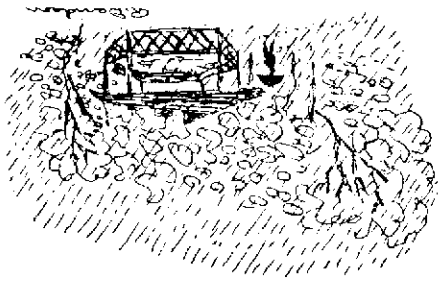

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